

**WISCONSIN HEALTH INSURANCE RISK SHARING PLAN (HIRSP)
HIPAA PRIVACY COMPLAINT**

The Privacy Rule standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) P.L. 104-191 require HIRSP Authority, as a covered entity, to implement processes that give policyholders certain rights regarding individually identifiable health information. The information requested on this form is needed to comply with those Privacy Rule requirements.

Provision of the information that is requested on this form is voluntary. Although the use of this version of the form is voluntary, all of the information outlined on this form is mandatory.

Personally identifiable information requested on this form is mandatory in order to process your request and will only be used for this purpose.

INSTRUCTIONS: Mail this completed form to the following address:

HIRSP
P.O. Box 8961
Madison WI 53708-8961

SECTION I — POLICYHOLDER INFORMATION

Name — Last, First, Middle Initial	HIRSP Identification Number
Address — Street, City, State, ZIP Code	Telephone Number ()

SECTION II — COMPLAINT POLICY SUMMARY

You have the right to file a complaint with HIRSP about our compliance with our *Notice of Privacy Practices* or our privacy policies and procedures. HIRSP will investigate your complaint and provide you with a written response. HIRSP will not require you to waive any rights you may have under federal or state privacy or other law to file your complaint, nor will filing your complaint affect the payment made by HIRSP for the health care coverage benefits provided to you. Further, you will not lose benefits or eligibility or otherwise be retaliated against for filing a complaint. To exercise this right, complete, sign, and date this form, then mail this complaint to the address listed above.

If you have questions, need additional information or assistance in completing your complaint, contact Customer Service at 1-800-828-4777 or (608) 221-4551. You may in addition to, or instead of, filing a complaint with HIRSP, file a complaint with the United States Department of Health and Human Services. For information on the procedure for doing this, please contact HIRSP at the above location or call Customer Service at 1-800-828-4777.

SECTION III — POLICYHOLDER'S COMPLAINT

Give a concise statement of your complaint.

SECTION III — POLICYHOLDER'S COMPLAINT (Continued)

Give a concise statement of the resolution you seek for your complaint.

SECTION IV — SIGNATURES

Please sign the form and complete the appropriate information.

SIGNATURE — PolicyholderDate Signed

If this request is from a personal representative on behalf of the policyholder, provide a copy of the documentation to support the representation and complete the following:

Name — Personal RepresentativeRelationship to policyholder

SIGNATURE — Personal RepresentativeDate Signed
